SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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John Doe No. 4 (a/k/a "120653"),

Plaintiff,

-against-

Rockefeller University, The Rockefeller University Hospital, and The Hospital for Special Surgery,

Defendants.

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VERIFIED COMPLAINT

Index No.:

Date Purchased:

Plaintiff John Doe No. 4 (a/k/a "120653"), by and through his attorneys, Joseph Lanni, Esq., and The Jacob D. Fuchsberg Law Firm, L.L.P., as and for his Verified Complaint, complaining of the defendants, respectfully alleges on information and belief as follows:

Introduction

1. John Doe No. 4 (a/k/a "120653")[1] contracted acute poliomyelitis in 1954 when he was nine months old. John Doe No. 4 was a post polio syndrome patient and research subject[2] at The Hospital for Special Surgery (HSS[3]) during the period

[1] "John Doe No. #4 (a/k/a '120653')" is an alias and pseudonym for the true identity of the plaintiff in this action; it is used to protect the identity of the plaintiff who is a sexual offense victim pursuant to N.Y. Civil Rights Law § 50-b. The addition of "a/k/a '120653'" to the alias is a designation used to distinguish this plaintiff from any other former research subject and patient who files an action against the defendants for the actions of Reginald M. Archibald, M.D., using the "John Doe" pseudonym. "John Doe No. #4 (a/k/a '120653')" is used interchangeably with "John Doe No. 4" to identify the plaintiff throughout the text of this pleading and will be so used throughout the proceedings in this case.

[2] Post polio syndrome patients like John Doe No. 4 at HSS were simultaneously research subjects in the course of his activities as a licensed medical doctor conducting biomedical research and treating patients; therefore, the terms "research subjects", "research subject", "patients", and "patient" are used interchangeably throughout this complaint to mean the same thing.

1954 - 1979. John Doe No. 4 was one of the subjects of a research project that involved experimental surgeries transferring and implanting healthy muscle and tendon into pediatric polio patient's paralyzed or weakened limbs. He was admitted to HSS on multiple occasions; some admissions were for protracted periods. During the HSS admissions, he underwent experimental surgeries and extensive rehabilitation. John Doe No. 4 also received substantial outpatient treatment at HSS during this time. While in the care and custody of HSS during the hospital admissions, John Doe No. 4 was occasionally brought to Rockefeller University and The Rockefeller University Hospital (RU/RUH[4]) ostensibly for evaluation by Reginald M. Archibald, M.D., as part of a study for child growth and development.

2. Reginald M. Archibald, M.D., was a researcher at defendants Rockefeller University and The Rockefeller University Hospital during the years 1947 – 1982. Archibald was an employee of Rockefeller University; he was also a pedophile. Archibald exploited his position with RU/RUH and status as a medical doctor to perpetrate a fraudulent research scheme and criminal enterprise during the period 1960 – 1980 that enabled him to gain access to underage research subjects and patients and commit pedophilic criminal acts of sexual abuse on these unsuspecting children. Archibald exploited opportunities to recruit thousands of

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[3] "Hospital for Special Surgery is variously referred to as "HSS" throughout this complaint; "Hospital for Special Surgery" and "HSS" are used interchangeably to refer to the same defendant.

[4] "Rockefeller University" is variously referred to as "RU" and "The Rockefeller University Hospital" is variously referred to as "RUH" throughout this complaint. "Rockefeller University" and "The Rockefeller University Hospital" and "RU/RUH" are used interchangeably to refer to the same defendant.

victims for his fraudulent research project on the growth and development of children.

3. Contemporaneously with Archibald's employment as a biomedical researcher at RU/RUH, The Hospital for Special Surgery conducted its biomedical research on poliomyelitis patients. John Doe No. 4 (a/k/a "120653") was one of Archibald's research subjects and patients[5] at RU/RUH on the occasions that he was brought over to that institution by HSS personnel for "evaluation". Archibald and others sexually abused John Doe No. 4 during the time that he was a pediatric post polio syndrome patient in the care and custody of RU/RUH and HSS.

4. RU/RUH were aware that Archibald's work and conduct at their institution was the subject of a grand jury investigation in 1960. RU/RUH received subpoenas from prosecutors to release Archibald's records on adolescent patients. Despite the knowledge in 1960 that Archibald's research activities had raised the suspicions of prosecutors about criminal activity directed at the children in their care, RU/RUH did not investigate Archibald's research projects, methods and activities.

5. RU/RUH and HSS committed systematic and systemic failures to exercise their requisite institutional duty, responsibility and obligation to review, supervise,

[5] Archibald's patients at RU/RUH were simultaneously research subjects in the course of his activities as a licensed medical doctor conducting biomedical research and treating patients; therefore, the terms "research subjects", "research subject", "patients", and "patient" are used interchangeably throughout this complaint to mean the same thing.

monitor, audit, investigate, assess and evaluate the "research projects" undertaken by Archibald and other researchers to ensure that the rights, safety and welfare of their research subjects and patients were safeguarded. RU/RUH and HSS were mandated to specifically engage in oversight of research activities pursuant to the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects that were existent at the time. RU/RUH's institutional failures to exercise proper and adequate oversight permitted Archibald to perpetrate his fraudulent research scheme and commit sexual offenses and fraudulent and unethical acts against the underage patients in its care and custody including John Doe No. 4. HSS's institutional failures to exercise proper and adequate oversight of the researchers and personnel caring for the pediatric post polio syndrome patients in its custody permitted John Doe No. 4 to be subjected to the criminal, fraudulent and unethical behavior of researchers, employees and health care personnel.

6. Archibald's and others' predatory behavior against John Doe No. 4 at RU/RUH and HSS constituted sexual abuse and sexual offenses against minors under the N.Y. Penal Law.

7. Archibald's status as a biomedical researcher, recipient of federal grants to conduct research, and licensure as a medical doctor engaged in research on patients created special duties of care requiring adherence to federal policy and the standards, guidelines and principles governing and regulating ethical

biomedical research on human subjects.

8. RU/RUH's status as a biomedical research institution and recipient of federal grants to conduct research on patients created special duties of care requiring adherence to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

9. HSS's status as a hospital conducting biomedical research on pediatric polio patients similarly created special duties of care that required compliance with the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

10. The foregoing special duties of care were extraordinarily demanding when it came to research subjects and patients, including children, who were incapable of consent. RU/RUH and HSS violated their respective special duties of care owed to John Doe No. 4. RU/RUH's and HSS's violation of the special duties of care owed to John Doe No. 4 caused, contributed to and were substantial factors that resulted in the sexual abuse, crimes, fraud and unethical acts perpetrated by Archibald and others against him and resulted in his consequent injuries, harm, losses and damages.

Parties

11. John Doe No. 4 (a/k/a "120653") is a resident, domicile and citizen of the State of

New York.

12. John Doe No. 4 resides at 178 Dartmouth Loop, Staten Island, NY 10306.

13. John Doe No. 4 resides in Richmond County.

14. Rockefeller University is a private graduate university and biomedical research institution with principal executive offices, principal administrative offices, principal place of business, research laboratories, clinical offices, hospital, and medical and scientific facilities located at 1230 York Avenue, New York, NY 10065.

15. Rockefeller University is a graduate university and biomedical research institution with IRS 501(c)(3) tax-exempt status.

16. Rockefeller University is a purported not-for-profit corporation.

17. The Rockefeller University Hospital is a biomedical research hospital with principal executive offices, principal administrative offices, principal place of business, research laboratories, clinical offices, examination rooms, patient care rooms, operating rooms, and medical facilities located at 1230 York Avenue, New York, NY 10065.

18. The Rockefeller University Hospital is a subsidiary corporate entity, division, department, unit, and/or component of parent entity Rockefeller University.

19. The Rockefeller University Hospital is owned, operated, controlled, directed, funded, administered and managed by Rockefeller University.

20. Rockefeller University is the corporate alter ego of The Rockefeller University Hospital. RUH is also the corporate alter ego of RU. RU and RUH are legally and factually owned, operated, controlled, directed, funded, administered and managed as one and the same institution, corporation and/or entity.

21. The Hospital for Special Surgery is a purported domestic not for profit corporation.

22. The Hospital for Special Surgery is a private hospital and biomedical research institution with principal executive offices, principal administrative offices, principal place of business, clinical offices, hospital, and medical and scientific facilities located at 535 East 70th St., New York, NY 10021.

Jurisdiction

23. The jurisdiction of this court is premised upon the principal place of business of the defendants in the State of New York, and the location of the transactions, occurrences, conduct, acts and omissions constituting the events at issue in this

action in the State of New York.

Venue

24. The venue of this action is premised upon the principal place of business of the defendants in the County of New York, and the location of the transactions, occurrences, conduct, acts and omissions constituting the events at issue in this action in the County of New York.

Jury Demand

25. The plaintiff demands trial by jury of all issues of fact in this action pursuant to the applicable statutes and rules.

Facts Common to All Counts

Overview – The Defendants' Violated Special Duties of Care Owed to John Doe No. 4

26. John Doe No. 4 (a/k/a "120653") contracted acute poliomyelitis in 1954 when he was nine months old. John Doe No. 4 was a pediatric polio patient and research subject at The Hospital for Special Surgery (HSS) during the period 1954 - 1979.

27. John Doe No. 4 was one of the subjects of a research project at HSS that involved experimental surgeries transferring and implanting healthy muscle and tendon into pediatric polio patients' paralyzed or weakened limbs. John Doe No. 4 was admitted to HSS on several occasions in the 1950's and 1960's; some admissions were for protracted durations of time. During the HSS admissions, John Doe No.

4 underwent experimental surgeries and extensive rehabilitation. John Doe No. 4 also received substantial outpatient treatment at HSS until 1979.

28. While in the care and custody of HSS during the hospital admissions, John Doe No. 4 was occasionally brought to Rockefeller University and The Rockefeller University Hospital (RU/RUH) ostensibly for "evaluation" as part of a study about child growth and development by Reginald M. Archibald, M.D.

29. Reginald M. Archibald, M.D., was a researcher at defendants Rockefeller University and Rockefeller University Hospital during the years 1947 – 1982.

30. Archibald was an employee of Rockefeller University.

31. Archibald was also a pedophile.

32. Archibald exploited his position with RU/RUH and status as a medical doctor to perpetrate a fraudulent research scheme and criminal enterprise at the institution that enabled him to gain access to boys and girls to commit pedophilic sexual offenses and sexually abuse unsuspecting research subjects and patients.

33. Archibald exploited the anxieties and concerns of parents about the growth and development of their children to recruit thousands of victims to his fraudulent research project.

34. Archibald also exploited the ready supply of victims who were pediatric inpatients at HSS for the experimental surgeries on post polio syndrome patients.

35. John Doe No. 4 (a/k/a "120653") was sexually abused while an underage biomedical research subject in the care and custody of RU/RUH and HSS in the 1950's and 1960's.

36. John Doe No. 4 was one of Archibald's research subjects and patients; he was also one of Archibald's sexual abuse victims.

37. Unscrupulous HSS health care personnel also sexually abused John Doe No. 4.

38. RU/RUH and HSS committed systematic and systemic failures to exercise their requisite institutional duty, responsibility and obligation to properly and adequately review, supervise, monitor, audit, investigate and evaluate the research projects, methods and activities undertaken within their institutions.

39. The duty and responsibility to exercise proper and adequate oversight imposed on RU/RUH and HSS for the research projects in their institutions were necessary to ensure compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

40. Since Archibald received federally funded grants to conduct his research projects, RU/RUH were mandated to specifically engage in such proper and adequate oversight of his activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects that were existent at the time.

41. Since RU/RUH received federally funded grants to conduct human biomedical research projects, the institution was mandated to specifically engage in such proper and adequate oversight of research activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects that were existent at the time.

42. Since HSS conducted human biomedical research projects, the institution was mandated to specifically engage in such proper and adequate oversight of research activities pursuant to the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects that were existent at the time.

43. RU/RUH and HSS failed miserably during this time period to conduct the requisite oversight of the research activities described in this complaint.

44. RU/RUH and HSS failed miserably during this time period to conduct the requisite oversight of their employees participating in the research activities

described in this complaint.

45. RU/RUH prima facie accepted Archibald's "annual reports" about his work without any proper and adequate independent verification of accuracy.

46. RU/RUH allowed Archibald to arrange for an HSS pediatric post polio syndrome patient, John Doe No. 4, to be brought to RU/RUH for "evaluations" in his research project without the requisite consent forms, the knowledge and consent of the patient's parents or guardians, the maintaining of medical records, and/or medical or scientific justification.

47. HSS allowed its employees to transport its pediatric polio patient, John Doe No. 4, to RU/RUH for evaluations by Archibald without the requisite valid signed consent forms, the knowledge and consent of the patient's parents or guardians, the maintaining of medical records, an adequate investigation of Archibald's purposes, intentions or activities, and/or medical or scientific justification.

48. HSS failed to adequately chaperone a pediatric polio patient, John Doe No. 4, in its care and custody to prevent victimization by Archibald and others.

49. RU/RUH and HSS failed to exercise the requisite proper and adequate supervision of the employees assigned to work with pediatric polio patients to ensure that hospital personnel did not perpetrate acts of sexual abuse, crime, fraud

and unethical biomedical research activities against John Doe No. 4.

50. RU/RUH's and HSS's negligent institutional failures to exercise the requisite oversight permitted Archibald and others to commit criminal, fraudulent and unethical acts against John Doe No. 4 at the time that he was an underage research subject and patient in their care and custody.

51. RU/RUH's and HSS's negligence and breach of duty allowed Archibald and others to perpetrate a pervasive fraud scheme, engage in a criminal enterprise, and commit pedophilic sexual offenses against John Doe No. 4.

52. The criminal predatory behavior perpetrated upon John Doe No. 4 and thousands of others described in this complaint constituted sexual abuse and other sexual offenses against minors under the N.Y. Penal Law.

53. Archibald "treated" and conducted "research" on thousands of vulnerable underage research subjects and patients, including John Doe No. 4, at RU/RUH and HSS during the years 1947 – 1980.

54. Archibald engaged in a purported research project that was variously described by RU/RUH as "Mechanisms by which hormones exert their influence on the metabolic processes of growth and maturation of cartilage and bone, as seen in endocrine disorders" and "Study of Roentgenograms of Children with Marked

Retardation in Skeletal Maturation" during the years 1960 – 1980. Archibald received federal grants for his purported research projects involving endocrine disorders in children.

55. RU/RUH received federal grants for research projects involving the growth and development of children and medical conditions affecting children; therefore, it was required to comply with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects that were existent at the time.

56. HSS conducted research projects involving experimental surgeries on pediatric polio patients that transferred and implanted healthy muscle and tendon into paralyzed or weakened limbs; therefore, it was required to comply with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects that were existent at the time.

Archibald's Fraud Scheme

57. Archibald's research project at RU/RUH was part of a pervasive fraud scheme; thousands of underage research patients and their parents, including John Doe No. 4, were the victims of this fraud scheme.

58. The research projects were fraudulent for several reasons:

59. The projects were of dubious medical and scientific validity.

60. The projects were primarily designed to attract research subjects and patients by exploiting and manipulating the anxieties and concerns of parents who were worried whether their children were within the highly variable broad range of normal human growth and development.

61. The projects were designed to promote and stimulate the flow of underage research subjects and patients so as to supply a steady stream of ready victims for Archibald to access and prey upon for pedophilic sexual gratification purposes. In essence, the projects were a pretext for producing victims for the purposes of Archibald's pedophilic sexual gratification.

62. For example, there was nothing about the particular subjects of research – studies of cartilage, bone and x-rays – that required Archibald to direct patients to strip naked, examine and measure their genitalia, describe the appearance of secondary sex characteristics, order them to masturbate to ejaculation or be manually stimulated to ejaculation, obtain semen specimens, and/or photograph and film them naked, masturbating or in humiliating sexualized positions.

63. For example, Archibald's subjection of children not suffering from an endocrine disorder to the excess radiation of x-rays simply to predict adult height served no valid scientific or medical purpose. The prediction of adult height in and of itself

served no valid scientific or medical purpose. Indeed, its underlying premise served eugenic goals that had long since been scientifically discredited.

64. For example, the vast majority of the thousands of children who were Archibald's research subjects and patients, including John Doe No. 4, were clearly well within the highly variable broad range or statistical curve of normal human growth, development, and secondary sex characteristics, and exhibited no signs of an endocrine disorder.

65. Archibald lacked the professional medical credentials to undertake biomedical research in endocrinology or pediatric endocrinology; he had not completed any accredited graduate medical education residency program in the fields of endocrinology or pediatrics. While Archibald had graduated from medical school in Canada and was licensed to practice medicine in New York, he had only undergone limited training in the field of nephrology, i.e., kidney diseases and conditions.

66. In the course of Archibald's research projects and "treatment" of underage patients, he also engaged in the following fraudulent, unethical and criminal methods and activities:

67. Archibald made fraudulent diagnoses.

68. Archibald performed fraudulent examinations with ulterior motives that served no valid medical or scientific purpose.

69. Archibald fraudulently obtained specimens that served no valid medical or scientific purpose.

70. Archibald fraudulently advised parents about the medical necessity to schedule return patient visits for their children.

71. Archibald fraudulently advised parents about the medical utility of patient visits for the siblings of research subjects and patients.

72. Archibald arranged to forge parents' signatures on consent forms for "treatment and diagnostic procedures".

73. Archibald arranged to forge parents' signatures on consent forms for medical photographs.

74. Archibald arranged for the preparation of fraudulent consent forms providing "carte blanche" consent for examination that prima facie violated federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

75. Archibald arranged the preparation of fraudulent consent forms providing "carte blanche" consent for medical photographs that prima facie violated federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

76. Archibald's consent forms authorized the administering of unspecified "medications" that gave him the pretext to medicate research subjects and patients so that they would become more cooperative, less resistant and/or less likely to fully recall the entire encounter. The unspecified term "medications" would necessarily be inclusive of hypnotics, sedatives, amnestics, and soporifics such as benzodiazepines.

77. Archibald failed to obtain valid consent forms signed by parents or guardians to "evaluate", examine and/or treat underage research subjects and patients.

78. Archibald failed to maintain medical records for some underage research subjects and patients that he "evaluated", examined and/or treated in the course of his research projects.

79. Archibald failed to advise the parents or guardians of some underage research subjects and patients that they would be "evaluated", examined and/or treated in the course of his research projects and/or transported to RU/RUH for "evaluation".

80. Archibald concealed from HSS doctors and personnel the true purpose of his reasons for arranging the transfer of HSS pediatric polio patients to RU/RUH for inclusion in the purported research projects.

81. Archibald made fraudulent recommendations to parents related to the medical care and health status of their children that lacked medical purpose or necessity.

82. Archibald recruited underage research subjects and patients (i.e., victims) from the pediatric polio patients at HSS, John Doe No. 4, for inclusion in his purported research projects.

83. Archibald fraudulently concealed that the actual purpose of his "research project" was to gain access to underage research subjects and patients so as to victimize them for his own pedophilic sexual gratification purposes.

The Sexual Abuse – Archibald's Customary, Habitual and Routine Pattern or Modus Operandi During Patient Encounters

84. Archibald systematically and systemically sexually abused his underage research subjects and patients, including John Doe No. 4, as a customary, habitual and routine part of his "treatment", "diagnostic procedures", "examinations" and "research".

85. The majority of Archibald's research subjects and patients were male children.

86. Archibald customarily and habitually engaged in a series of criminal pedophilic activities and perpetrated sexual offenses that were cloaked in the guise of medical examinations on underage research subjects and patients.

87. Archibald's "examinations" mostly served no valid medical purpose, necessity, or legitimacy; they were performed to provide opportunity and access to Archibald to perpetrate pedophilic sexual offenses for his own deviant sexual gratification.

88. Specifically, Archibald's encounters with research subjects and patients customarily and habitually consisted of the following routine:

89. Archibald separated and isolated his underage research subjects and patients from their parents or guardians.

90. Archibald brought underage patients into his office or examination rooms at RUH.

91. Archibald locked the door to the room.

92. Archibald was nearly always alone with underage research subjects and patients in his office or examination room without any other health care professional, parent or chaperone present.

93. Archibald directed the underage research subjects and patients to completely

disrobe or compelled them to disrobe.

94. Archibald did not provide the underage research subjects and patients with a hospital gown for customary modesty purposes so as to ensure that they remained naked throughout the encounter.

95. Archibald "measured" most of his underage male patients' penises and testicles as a purported part of his "treatment" and "research".

96. Archibald measured underage male patients' penises when flaccid and sometimes erect.

97. Archibald photographed and/or filmed most of his underage research subjects and patients while they were naked; the photography and/or filming included selective close-ups of genitalia.

98. Archibald extensively fondled his underage male patients' penises and scrotums during purported examinations. Sometimes Archibald's purported examinations included to anus or rectum.

99. Archibald sometimes directed his underage male patients to masturbate to ejaculation; he assisted many patients to ejaculate with manual stimulation if they were unable to do so on their own.

100. Archibald's examinations, genital measurements, masturbation directives and/or semen specimen extractions pertaining to these underage patients were non-consensual; they occurred without the valid consent of the patients or their parents or guardians.

101. Archibald compelled underage patients to pose naked for photographs in humiliating and vulnerable positions.

102. Archibald's photographing and/or filming of underage male and female patients naked or male patients masturbating or ejaculating sometimes occurred clandestinely without the knowledge of their parents or guardians.

103. Archibald's photographing and/or filming of underage patients naked occurred without the valid consent of the patients or their parents.

104. Archibald sometimes observed underage male and female patients while they were naked or underage male patients while they were masturbating.

105. Archibald's photographs and/or films of his underage patients were made with RU/RUH and HSS equipment and sometimes with the assistance of RU/RUH staff.

106. Archibald conspired with other RU/RUH employees to create a compilation of photographs and/or films of naked, masturbating or ejaculating underage patients.

107. John Doe No. 4's experiences as a patient and research subject while in the temporary care and custody of Archibald and RU/RUH were generally consistent with Archibald's customary patterns and practices of pedophilia and sexual abuse.

RU/RUH's Misfeasance, Malfeasance & Institutional Failures

108. RU/RUH negligently committed numerous acts and omissions of misfeasance, malfeasance and institutional failure that included, but are not limited to, the following:

109. RU/RUH systematically developed "carte blanche" consent forms, including consents for "treatment" and "photographs" that violated federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects to promote and stimulate the steady flow of research subjects and patients.

110. RU/RUH failed to obtain valid consent forms signed by parents or guardians to "evaluate", examine and/or treat underage research subjects and patients, including those pediatric polio patients like John Doe No. 4 transported from HSS, for the purposes of inclusion in Archibald's research projects and his "evaluation", examination and/or treatment.

111. RU/RUH permitted Archibald to forego obtaining valid consent forms signed by parents or guardians to "evaluate", examine and/or treat underage research subjects and patients, including those pediatric polio patients like John Doe No. 4 transported from HSS, for the purposes of inclusion in Archibald's research projects and his "evaluation", examination and/or treatment.

112. RU/RUH failed to maintain medical records for some underage research subjects and patients that he "evaluated", examined and/or treated in the course of his research projects, including those pediatric polio patients like John Doe No. 4 transported from HSS.

113. RU/RUH permitted Archibald to fail to maintain medical records for some underage research subjects and patients that he "evaluated", examined and/or treated in the course of his research projects, including those pediatric polio patients like John Doe No. 4 transported from HSS.

114. RU/RUH failed to advise the parents or guardians of some underage research subjects and patients, including those pediatric polio patients like John Doe No. 4 transported from HSS, that they would be "evaluated", examined and/or treated in the course of RU/RUH research projects and/or transported to RU/RUH for "evaluation".

115. RU/RUH permitted Archibald to fail to advise the parents or guardians of some underage research subjects and patients, including those pediatric post polio syndrome patients like John Doe No. 4 transported from HSS, that they would be "evaluated", examined and/or treated in the course of his research projects and/or transported to RU/RUH for "evaluation".

116. Archibald made fraudulent recommendations to parents related to the medical care and health status of their children that lacked medical purpose or necessity.

117. Archibald recruited underage research subjects and patients (i.e., victims) from the HSS pediatric post polio syndrome patients, including John Doe No. 4, for inclusion in his purported research projects.

118. Archibald concealed from HSS doctors, nurses and personnel the true purpose of his reasons for arranging the transfer of pediatric post polio patients to RU/RUH for inclusion in the purported research projects.

119. RU/RUH was aware of many aspects of Archibald's customary and habitual activities during encounters with underage research subjects and patients.

120. RU/RUH was aware that Archibald was using "carte blanche" consent forms, including consents for "treatment" and "photographs", for underage research subjects and patients in his federally funded "research" projects.

121. RU/RUH was aware that Archibald was using its facilities and equipment to photograph and/or film underage male and female patients while they were naked or underage male patients while they were masturbating and/or ejaculating.

122. RU/RUH was aware that Archibald was sometimes using RU/RUH employees to perform the photography and/or filming of underage male and female patients while they were naked or underage male patients while they were masturbating and/or ejaculating.

123. RU/RUH was aware that Archibald had compiled a collection of thousands of photographs and/or films of underage male and female patients while they were naked or underage male patients while they were masturbating and/or ejaculating.

124. RU/RUH maintained in its possession Archibald's collection of thousands of such photographs and/or films of underage male and female patients.

125. RU/RUH never investigated or inquired into the medical or scientific purposes of Archibald's collection of photographs and/or films.

126. RU/RUH was aware and/or should have been aware that such a collection of photographs and/or films created the risk of intrusions into the medical privacy rights of these underage patients for untoward purposes.

127. RU/RUH failed to properly and adequately secure and protect Archibald's collection of photographs and/or films from unauthorized removal, theft, pilferage and/or potential distribution, dissemination and/or publication for untoward purposes.

128. RU/RUH fraudulently concealed that Archibald's customary, habitual and routine pattern of behaviors and activities during encounters with underage research subjects and patients were without valid medical or scientific purpose.

129. RU/RUH was aware that Archibald failed to obtain valid consent forms signed by parents or guardians to "evaluate", examine and/or treat underage research subjects and patients, including those pediatric polio patients like John Doe No. 4 transported from HSS, for the purposes of inclusion in Archibald's research projects and his evaluation, examination and/or treatment.

130. RU/RUH was aware that Archibald failed to maintain medical records for some underage research subjects and patients that he evaluated, examined and/or treated in the course of his research projects, including those pediatric polio patients like John Doe No. 4 transported from HSS.

131. RU/RUH was aware that Archibald failed to advise the parents or guardians of some underage research subjects and patients, including those pediatric polio

patients like John Doe No. 4 transported from HSS, that they would be evaluated, examined and/or treated in the course of his research projects and/or transported to RU/RUH for evaluation.

132. RU/RUH failed to exercise the requisite proper and adequate oversight and supervision of the Archibald and other employees assigned to work with underage patients and research subjects in its custody, including John Doe No. 4, to ensure that they did not perpetrate acts of sexual abuse, crime, fraud and unethical biomedical research activities against them.

133. RU/RUH did not properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess and inquire into Archibald's research projects, methods and activities as required by federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

134. RU/RUH did not properly and adequately conduct the foregoing requisite oversight to ensure that Archibald's research projects, methods and activities were in compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

135. John Doe No. 4 was one of the research subjects and patients in RU/RUH's temporary care and custody subjected to criminal, fraudulent and unethical acts.

136. RU/RUH's negligent institutional failures to exercise the foregoing requisite oversight caused, contributed to and were substantial factors resulting in Archibald and others committing criminal, fraudulent and unethical acts against the underage research subjects and patients in their care and custody including John Doe No. 4.

HSS's Misfeasance, Malfeasance & Institutional Failures

137. HSS negligently committed numerous acts of misfeasance, malfeasance and institutional failure that included, but are not limited to, the following:

138. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH for "evaluations" by Archibald without the requisite valid signed consent forms by the patients' parents or guardians.

139. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH without the knowledge and consent of patients' parents or guardians.

140. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH without maintaining medical records documenting the temporary transfers or the purposes of the same.

141. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH without adequate investigation of Archibald's purposes, intentions or activities, and/or medical or scientific justification.

142. HSS failed to adequately chaperone and supervise the pediatric polio patients and research subjects in its custody, including John Doe No. 4, who were transported to RU/RUH to prevent their victimization by Archibald.

143. HSS failed to adequately chaperone and supervise the pediatric polio patients and research subjects in its custody, including John Doe No. 4, to prevent their victimization.

144. HSS failed to exercise the requisite proper and adequate supervision of the employees assigned to work with pediatric polio patients and research subjects in its custody, including John Doe No. 4, to ensure that health care personnel did not perpetrate acts of sexual abuse, crime, fraud and unethical biomedical research activities against them.

145. HSS did not properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess and inquire into the full scope of Archibald's research projects, purposes, methods and activities before or at the time it transported its

pediatric polio patients and research subjects in its custody, including John Doe No. 4, to ensure full compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

146. HSS did not properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess and inquire into the full scope of its research projects, purposes, methods and activities as required by federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

147. HSS did not properly and adequately conduct the requisite oversight to ensure that its research projects, purposes, methods and activities were in full compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

148. John Doe No. 4 was one research subject and patient in HSS's care and custody subjected to criminal, fraudulent and unethical acts.

149. HSS's negligent institutional failures to exercise the foregoing requisite oversight caused, contributed to and were substantial factors resulting in Archibald and others committing criminal, fraudulent and unethical acts against John Doe No. 4.

Plaintiff John Doe No. 4's Experiences as a Biomedical Research Subject and Patient in the Care and Custody of HSS and RU/RUH

150. John Doe No. 4 was a polio patient and research subject at HSS during the period 1954 - 1979.

151. John Doe No. 4 contracted acute poliomyelitis in 1954 when he was nine months old.

152. John Doe No. 4 contracted acute poliomyelitis in September 1954. John Doe No. 4's parents took him to a hospital on Staten Island and he spent several weeks there. John Doe No. 4 was eventually transferred to another nearby hospital for physiotherapy; he remained at that hospital for two or more months.

153. John Doe No. 4 was transferred to HSS on his first birthday in December 1954. He remained hospitalized there for several months for continued physical therapy, rehabilitation and brace fitting. John Doe No. 4 recalls nothing about the 1954 - 1955 admission.

154. Polio left John Doe No. 4 with residual severe motor deficits in the left leg.

155. When John Doe No. 4 was brought to HSS, he was included as a subject in a research project or "special study" related to the treatment of pediatric polio patients. HSS's research project involved experimental surgeries transferring and implanting healthy muscle and tendon into pediatric polio patient's paralyzed or

weakened limbs.

156. Subsequently, John Doe No. 4 was admitted to HSS on several more occasions in the 1950's and 1960's. Some of the admissions were for protracted periods of time.

157. During the admissions, John Doe No. 4 underwent experimental surgeries involving transfers and implants of healthy muscle and tendon into the hip and knee region of his polio weakened left leg.

158. In the aftermath of these experimental surgeries, John Doe No. 4 would be immobilized in a cast that wrapped around his waist and pelvis, encompassed his left hip and leg to the forefoot, and encased the right hip to above the right knee. Despite the extensiveness of the cast, openings remained for John Doe No. 4's genitalia, buttocks and perineum to permit waste elimination and hygiene.

159. After removal of the casts, John Doe No. 4 would remain at HSS to undergo extensive rehabilitation and physical therapy.

160. John Doe No. 4 would be transported by gurney when he was casted.

161. After cast removal, John Doe No. 4 would be transported by wheelchair for a substantial period of time.

162. While admitted at HSS for these surgeries, John Doe No. 4 lived in a large ward with other pediatric polio patients.

163. John Doe No. 4 and other patients received educational lessons and tutoring in another part of the hospital; they would be transported in gurneys and wheelchairs for their lessons and tutoring.

164. John Doe No. 4 and other pediatric polio patients were transported to the physical therapy department in a different part of the hospital for treatment on nearly a daily basis.

165. Adjacent to the physical therapy department was a large heated pool.

166. After physical therapy, John Doe No. 4 and other pediatric polio patients were taken to the heated pool for continued exercises to strengthen their paralyzed or weakened limbs.

167. Nurses, nurses' aides and orderlies provided care to the children, including John Doe No. 4, in the pediatric polio ward.

168. Physicians often made "rounds" in the pediatric polio ward to examine the patients. "Dr. Harvey", "Dr. Wilson", "Dr. Adler", "Dr. Match", "Dr. Kennedy",

and "Dr. Patterson" examined John Doe No. 4 during rounds. The full identity of these physicians remains unknown to John Doe No. 4. Dr. Wilson and Dr. Match performed or participated in at least one of the experimental surgeries on John Doe No. 4.

169. The HSS physicians were very kind and gentle to John Doe No. 4 and the other polio patients on the pediatric polio ward. So were the nurses, nurses' aides and orderlies usually working during the day shift. The nurses, nurses' aides and orderlies usually working the night shift were not so nice.

170. Other doctors whom John Doe No. 4 did not know sometimes joined the above named HSS doctors examining the pediatric polio patients on rounds.

171. One day, a doctor that John Doe No. 4 did not know joined the HSS doctors on rounds in the pediatric polio ward. This doctor was present when the HSS doctors examined John Doe No. 4. John Doe No. 4 would later see this doctor in a different context.

172. While in the care and custody of HSS during hospital admissions for the experimental surgeries in the 1950's and 1960's, John Doe No. 4 was occasionally brought to RU/RUH. He was 7 – 10 years old at the time.

173. John Doe No. 4 was sometimes told or overheard hospital personnel say on those

occasions that he was to be taken to "Rockefeller".

174. An orderly transported John Doe No. 4 on a gurney or in a wheelchair to RU/RUH.

175. John Doe No. 4 was sometimes transported from HSS through pedestrian tunnels leading toward the RU/RUH campus. Other times John Doe No. 4 would be transported from HSS entirely outdoors to RU/RUH.

176. The orderly transported John Doe No. 4 to medical offices in RU/RUH and leave him there.

177. John Doe No. 4 would be brought into the medical offices to be "examined" by a doctor. The doctor was the person he had previously seen attending rounds at HSS with his usual doctors in the pediatric polio ward.

178. On each occasion that the RU/RUH doctor "examined" John Doe No. 4, the following generally took place:

179. There were no health care personnel other than the doctor present in the room when the "examinations" were performed on John Doe No. 4.

180. The doctor at RU/RUH would entirely remove John Doe No. 4's hospital clothes

so that he was naked for the "examination". No hospital gown was provided for modesty purposes.

181. The doctor "examined" John Doe No. 4 by touching his genitals to the point of fondling, inserting a finger into the rectum, and taking photos of him naked with a camera.

182. The doctor then helped John Doe No. 4 get dressed after the "examination" was finished.

183. John Doe No. 4 was then brought out to a waiting room to await an orderly to transport him back to HSS.

184. The "examination" by the RU/RUH doctor was non-consensual; there were no valid consent forms signed by John Doe No. 4's parents or guardians for this "examination" or for any type of evaluation or treatment at RU/RUH. John Doe No. 4's parents were not made aware that he was taken to RU/RUH. There were no valid consent forms signed by John Doe No. 4's parents or guardians for the transfer to the temporary custody of RU/RUH.

185. John Doe No. 4 was not chaperoned or supervised by HSS's nurses, nurses' aides or orderlies when "examined" by this doctor at RU/RUH.

186. John Doe No. 4 was not chaperoned or supervised by RU/RUH's nurses, nurses' aides or orderlies when "examined" by this doctor.

187. Many years after John Doe No. 4's foregoing experiences as a pediatric polio patient at HSS and RU/RUH, he recognized the doctor performing the "examinations" upon him at RU/RUH through a photograph and article appearing in a newspaper.

188. John Doe No. 4 identified the doctor performing the foregoing "examinations" to be Archibald.

189. During protracted HSS admissions, John Doe No. 4, would miss his parents and sometimes cry at night for his mother. Other times, John Doe No. 4, would feel pain from the surgeries at night, cry out and ask for help. Still other times, John Doe No. 4 and other pediatric polio patients, would not want to go to sleep at night but rather stay up and talk or play games.

190. Sometimes during these occasions, the night shift nurses and nurses' aides would get angry, grab John Doe No. 4 by the neck or shoulders, and shake him back and forth telling him to "shut up". John Doe No. 4 was also put in a wooden wheelchair and placed in a janitor's closet for long periods of time as punishment.

191. On a few occasions when John Doe No. 4 could not sleep at night, a nurse or

nurses' aide brought him by gurney down to the underground tunnels or basement where she met a man who appeared to be a hospital orderly for sexual encounters. The couple partially disrobed and engaged in sexual acts in John Doe No. 4's presence. The couple would tease John Doe No. 4, force him to watch, place his hand on the nurse's breast or genital area, or kiss the nurse while the man laughed.

The Ethical Standards, Guidelines & Principles Governing & Regulating Biomedical Research on Human Subjects

192. The ethical standards, guidelines and principles governing and regulating biomedical research on human subjects existent at the time John Doe No. 4 was in the care and custody of HSS and RU/RUH as a pediatric polio patient and research subject in the 1950's and 1960's are codified in the Nuremberg Code, the Helsinki Declaration and the AMA's Ethical Guidelines for Clinical Investigation.

The Nuremberg Code

193. The Nuremberg Code is the most important document in the history of the ethics of biomedical research on human subjects. The code was formulated in August 1947, in Nuremberg, Germany, during war crimes trials of Nazi doctors accused of conducting murderous and torturous human experiments in the concentration camps (i.e., "The Doctors' Trial"). It serves as the blueprint for today's principles that ensure the rights of human subjects in biomedical research.

194. In pertinent part, The Nuremberg Code[6] states the following:

[6] See, The Nuremberg Code; Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 4 0, Nuremberg, Germany, October 1946–April 1949; Washington, D.C.: U.S.

> The Nuremberg Code
> "1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.
> .....
> 4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
> .....
> 7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

195. The "Doctor's Trial" before the Nuremberg War Crimes Tribunal defined the ideas that shaped the standards of biomedical research ethics.

The 1964 Helsinki Declaration

196. The Declaration of Helsinki in 1964[7] was the next important set of standards, guidelines and principles governing and regulating biomedical research on human subjects. It states, in pertinent part, as follows:

"I. BASIC PRINCIPLES

G.P.O, 1949–1953.

[7] See, Declaration of Helsinki, Recommendations guiding doctors in clinical research, World Medical Assembly, 1964.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.
3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.
4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.
.....
II. CLINICAL RESEARCH COMBINED WITH PROFESSIONAL CARE
..... [T]he doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity, consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.
.....
III. NON-THERAPEUTIC CLINICAL RESEARCH
In the purely scientific application of clinical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.
The nature, the purpose and the risk of clinical research must be explained to the subject by the doctor.
3a. Clinical research on a human being cannot be undertaken without his free consent after he has been informed; if he is legally incompetent, the consent of the legal guardian should be procured.
.....
4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.
....."

The 1966 Ethical Guidelines for Clinical Investigation of the American Medical Association

197. The American Medical Association's Ethical Guidelines for Clinical Investigation published in 1966[8] supplemented the 1947 Nuremberg Code and 1964 Declaration of Helsinki in defining the standards, guidelines and principles

[8] See, Ethical Guidelines for Clinical Investigation, American Medical Association, JAMA, 1966.

governing and regulating biomedical research on human subjects. It states, in pertinent part, as follows:

> "2. In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.
> .....
> .....
> B. Voluntary consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following :
> .....
> (b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits, (c) an offer to answer any inquiries concerning the drug or procedure, and In clinical investigation primarily for the accumulation of scientific knowledge – Adequate safeguards must be provided - for the welfare, safety and comfort of the subject.
> B. Consent, in writing, should be obtained from the subject, or from his legally authorized representative if the subject lacks the capacity to consent, following a disclosure of the fact that an investigational drug or procedure is to be used, (b) a reasonable explanation of the nature of the procedure to be used and risks to be expected, and (c) an offer to answer any inquiries concerning the drug or procedure.
> C. Minors or mentally incompetent persons may be used as subjects only if: The nature of the investigation is such that mentally competent adults would not be suitable subjects. Consent, in writing, is given by a legally authorized representative of the subject under circumstances in

which an informed and prudent adult would reasonably be expected to volunteer himself or his child as a subject."

Predicate Sexual Offenses & Crimes – N.Y. Penal Law Violations

198. Archibald and others committed the following sexual offenses under the N.Y. Penal Law or the predecessor statutes pertaining to the same criminal conduct in the course of his encounters with John Doe No. 4 at RU/RUH and HSS:

199. Archibald and others violated N.Y. Penal Law §130.52 "Forcible touching"; N.Y. Penal Law §130.55, "Sexual abuse in the third degree"; N.Y. Penal Law §130.60, "Sexual abuse in the second degree"; N.Y. Penal Law §130.65, "Sexual abuse in the first degree"; N.Y. Penal Law §130.91, "Sexually motivated felony"; N.Y. Penal Law §263.05, "Use of a child in a sexual performance"; N.Y. Penal Law §263.10, "Promoting an obscene sexual performance by a child"; N.Y. Penal Law §263.11 "Possessing a sexual performance by a child"; and N.Y. Penal Law §263.15, "Promoting an sexual performance by a child".

Causes of Action

First Count – Negligence

200. Plaintiff John Doe No. 4 (a/k/a "120653") repeats, reiterates and re-alleges each and every allegation as previously set forth in paragraphs 1 - 199 of this Verified Complaint as if those allegations were fully and completely repeated, reiterated and re-alleged in the entirety in this paragraph, cause of action, and count.

201. RU/RUH and HSS and its employees and agents owed the following duties of reasonable care and special duties of care to underage research subjects and patients in its care and custody, including John Doe No. 4, as a biomedical research institution and hospital engaged in research on underage human subjects:

202. RU/RUH owed a duty to properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess and inquire into the validity of the medical or scientific purpose of Archibald's research projects, methods and activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

203. RU/RUH owed a duty to properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess, control, direct and guide Archibald's research projects, methods and activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

204. RU/RUH owed a duty to properly and adequately conduct oversight of Archibald's research projects, methods and activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

205. RU/RUH owed a special duty of care to conduct biomedical research and medical treatment in accordance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects to protect them from injury and harm.

206. RU/RUH owed a special duty of care to ensure that Archibald's research projects served a valid medical or scientific purpose, were medically and scientifically ethical, were in compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects, and did not cause the research subjects and patients injury and harm.

207. RU/RUH owed a duty to properly and adequately secure and protect Archibald's collection of thousands of photographs and/or films of underage patients from unauthorized removal, theft, pilferage, distribution, dissemination and/or publication for untoward purposes.

208. RU/RUH owed a special duty of care that arose out of its own conduct as a biomedical research institution to refrain from practices that created or increased the foreseeable risk of harm to research subjects and patients through the conduct of a researcher whose projects, methods and activities were not subject to proper and adequate oversight in accordance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

209. RU/RUH owed a special duty of care that arose out of its own conduct as a biomedical research institution to refrain from practices that created or increased the foreseeable risk of harm to research subjects and patients through the conduct of a researcher whose projects, methods and activities were the subject of a grand jury investigation and complaints to hospital administration.

210. HSS owed a duty to properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess and inquire into its research projects, methods and activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

211. HSS owed a duty to properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess, control, direct and guide its research projects, methods and activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

212. RU/RUH owed a duty to properly and adequately conduct oversight of its research projects, methods and activities pursuant to federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

213. HSS owed a special duty of care to conduct biomedical research and medical treatment in accordance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects to protect them from injury and harm.

214. HSS owed a special duty of care to ensure that its research projects served a valid medical or scientific purpose, were medically and scientifically ethical, were in compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects, and did not cause the research subjects and patients injury and harm.

215. HSS owed a special duty of care that arose out of its own conduct as a biomedical research institution to refrain from practices that created or increased the foreseeable risk of harm to research subjects and patients through the conduct of a researcher whose projects, methods and activities were not subject to proper and adequate oversight in accordance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

216. HSS owed a special duty of care that arose out of its own conduct as a biomedical research institution to refrain from practices that created or increased the foreseeable risk of harm to research subjects and patients through the conduct of a

researcher whose projects, methods and activities were the subject of a grand jury investigation and complaints to hospital administration.

217. HSS owed a special duty of care to ensure that Archibald's research projects, purposes, methods and activities were compliant with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects prior to transferring any of its pediatric polio patients to the care and custody of Archibald and RU/RUH.

218. HSS owed a special duty of care to ensure that it conducted adequate oversight of Archibald's research projects, purposes, methods and activities to ensure compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects prior to transferring any of its pediatric polio patients to the care and custody of Archibald and RU/RUH.

219. RU/RUH and HSS and their employees and agents violated, breached, departed and deviated from, and did not adhere to their duties of reasonable care and special duties of care owed to underage research subjects and patients in their care and custody, including John Doe No. 4, in the following manner:

220. RU/RUH never properly and adequately reviewed, supervised, monitored, investigated, audited, evaluated, assessed, and/or inquired into the validity of the

medical or scientific purpose of Archibald's research projects, methods and activities in accordance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

221. RU/RUH never properly and adequately reviewed, supervised, monitored, investigated, audited, evaluated, assessed, controlled, directed and/or guided Archibald's research projects, methods and activities to ensure compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

222. RU/RUH never properly and adequately conducted the requisite oversight of Archibald's research projects, methods and activities to ensure compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

223. RU/RUH never adhered to its special duty of care to underage research subjects and patients in its care and custody to protect them from Archibald's unethical biomedical research and medical treatment that departed and deviated from federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

224. RU/RUH never adhered to its special duty of care to ensure that Archibald's

research projects served a valid medical or scientific purpose, were medically and scientifically ethical, were in compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects, and did not cause the research subjects and patients injury and harm.

225. RU/RUH never adhered to its duty of care to properly and adequately secure and protect Archibald's compilation and collection of thousands of the photographs and/or films of underage patients from unauthorized removal, theft, pilferage, distribution, dissemination and/or publication for untoward purposes.

226. RU/RUH never adhered to its special duty of care to protect underage research subjects and patients in its care and custody from the foreseeable risk of harm created or caused by the conduct of a researcher whose projects, methods and activities were not subject to proper and adequate oversight as required by federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

227. RU/RUH never adhered to its special duty of care to protect underage research subjects and patients in its care and custody from the foreseeable risk of harm created or caused by the conduct of a researcher whose projects, methods and activities were the subject of a grand jury investigation and complaints to hospital administration.

228. RU/RUH negligently failed to properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess, and/or inquire into the validity of the medical or scientific purpose of Archibald's research projects, methods and activities in accordance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

229. RU/RUH negligently failed to properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess, control, direct and/or guide Archibald's research projects, methods and activities to ensure compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

230. RU/RUH negligently failed to properly and adequately conduct the requisite oversight of Archibald's research projects, methods and activities or negligently failed to adequately conduct such oversight to ensure compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

231. RU/RUH negligently failed to adhere to its special duty of care to underage research subjects and patients in its care and custody to protect them from Archibald's unethical biomedical research and medical treatment that departed and deviated from federal policy and the standards, guidelines and principles

governing and regulating ethical biomedical research on human subjects that were existent at the time and subjected them to injury and harm.

232. RU/RUH negligently failed to adhere to its special duty of care to ensure that Archibald's research projects served a valid medical or scientific purpose, were medically and scientifically ethical, were in compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects and did not cause the research subjects and patients injury and harm.

233. RU/RUH negligently failed to properly and adequately secure and protect Archibald's collection of photographs and/or films of underage patients from unauthorized removal, theft, pilferage, distribution, dissemination and/or publication for untoward purposes.

234. RU/RUH was negligent because they failed to protect underage research subjects and patients in its care and custody from the foreseeable risk of harm presented by the unethical or criminal conduct of Archibald whose projects, methods and activities were not subject to proper and adequate oversight as required by federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

235. RU/RUH was negligent because it failed to protect underage research subjects

and patients in its care and custody from the foreseeable risk of harm presented by the unethical or criminal conduct of Archibald whose projects, methods and activities were the subject of a grand jury investigation and complaints to hospital administration.

236. RU/RUH was negligent because it failed to comply with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects, including the Nuremberg Code of 1947, Declaration of Helsinki of 1964, and AMA Ethical Guidelines for Clinical Investigation of 1966, in conducting oversight of Archibald's research projects, methods and activities.

237. RU/RUH was negligent because it failed to ensure that Archibald was in compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects, including the Nuremberg Code of 1947, Declaration of Helsinki of 1964, and AMA Ethical Guidelines for Clinical Investigation of 1966.

238. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH for "evaluations" by Archibald without the requisite valid signed consent forms by the patients' parents or guardians.

239. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH without the knowledge and consent of patients' parents or guardians.

240. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH without maintaining medical records documenting the temporary transfers or the purposes of the same.

241. HSS allowed its employees to transport its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to RU/RUH without adequate investigation of Archibald's purposes, intentions or activities, and/or medical or scientific justification.

242. HSS failed to adequately chaperone and supervise the pediatric polio patients and research subjects in its custody, including John Doe No. 4, who were transported to RU/RUH to prevent their victimization by Archibald.

243. HSS failed to adequately chaperone and supervise the pediatric polio patients and research subjects in its custody, including John Doe No. 4, to prevent their victimization.

244. HSS failed to exercise the requisite proper and adequate supervision of the

employees assigned to work with pediatric polio patients and research subjects in its custody, including John Doe No. 4, to ensure that health care personnel did not perpetrate acts of sexual abuse, crime, fraud and unethical biomedical research activities against them.

245. HSS did not properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess and inquire into the full scope of Archibald's research projects, purposes, methods and activities before or at the time it transported its pediatric polio patients and research subjects in its custody, including John Doe No. 4, to ensure full compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

246. HSS did not properly and adequately review, supervise, monitor, investigate, audit, evaluate, assess and inquire into the full scope of its research projects, purposes, methods and activities as required by federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

247. HSS did not properly and adequately conduct the requisite oversight to ensure that its research projects, purposes, methods and activities were in full compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

248. HSS was negligent because it failed to protect underage research subjects and patients in its care and custody from the foreseeable risk of harm presented by the unethical or criminal conduct of employees and health care personnel whose methods and activities were not subject to proper and adequate oversight as required by federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects.

249. HSS was negligent because it failed to protect underage research subjects and patients in its care and custody from the foreseeable risk of harm presented by the unethical or criminal conduct of employees and health care personnel whose methods and activities were the subject of a grand jury investigation and complaints to hospital administration.

250. HSS was negligent because it failed to comply with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects, including the Nuremberg Code of 1947, Declaration of Helsinki of 1964, and AMA Ethical Guidelines for Clinical Investigation of 1966, in conducting oversight of its research projects, methods and activities.

251. HSS was negligent because it failed to ensure that Archibald was in compliance with federal policy and the standards, guidelines and principles governing and regulating ethical biomedical research on human subjects, including the

Nuremberg Code of 1947, Declaration of Helsinki of 1964, and AMA Ethical Guidelines for Clinical Investigation of 1966 before transferring pediatric polio patients to the care and custody of Archibald and RU/RUH.

252. The negligence of RU/RUH and HSS caused, created and/or increased the foreseeable nature of Archibald's and other's unethical and criminal conduct and placed it within the scope of the risks presented by the circumstances under which underage research subjects and patients, including John Doe No. 4, were in its care and custody.

253. Because RU/RUH and HSS and its employees and agents negligently violated, breached, departed and deviated from, and did not adhere to their duties of reasonable care and special duties of care owed to underage research subjects and patients in its care and custody, including John Doe No. 4, it allowed and permitted Archibald and others to commit the foregoing enumerated crimes under the N.Y. Penal Law, including pedophilic sexual offenses and sexual abuse, against John Doe No. 4.

254. Because RU/RUH and HSS and its employees and agents negligently violated, breached, and departed and deviated from their duties of reasonable care and special duties of care owed to underage research subjects and patients in its care and custody, including John Doe No. 4, it allowed and permitted Archibald and other employees and agents to injure, harm and damage John Doe No. 4.

255. Because RU/RUH and HSS and its employees and agents negligently violated, breached, and departed and deviated from to their foregoing duties of reasonable care and special duties of care owed to underage research subjects and patients in its care and custody, including John Doe No. 4, it failed to prevent and stop Archibald and other employees and agents from injuring, harming and damaging John Doe No. 4.

256. RU/RUH and HSS's foregoing negligence caused, contributed to, and were substantial factors resulting in Archibald's and other's commission of the foregoing enumerated crimes under the N.Y. Penal Law, including pedophilic sexual offenses and sexual abuse, perpetrated against John Doe No. 4.

257. RU/RUH and HSS's foregoing negligence caused, contributed to, and were substantial factors resulting in the injuries, harm, losses and damages sustained by John Doe No. 4.

258. RU/RUH and HSS are vicariously liable for the foregoing unethical and criminal conduct of Archibald and other employees and agents who were part of the "research" and "treatment" activities involving John Doe No. 4.

259. The negligence of RU/RUH and HSS was reckless and exhibited systematic and systemic gross indifference to the proper and adequate care and custody of John

Doe No. 4.

260. The negligence of RU/RUH and HSS was reckless and constituted systematic and systemic gross patient neglect of John Doe No. 4.

261. The injuries, harm, losses and damages sustained by John Doe No. 4 were caused solely and wholly by virtue of the foregoing negligence of RU/RUH and HSS and its employees and agents and were in no way caused and/or contributed to by the plaintiff.

262. By reason of the foregoing, plaintiff by John Doe No. 4 is entitled to monetary damages, including punitive damages, on the first count for his non-economic and economic injuries that exceed the jurisdictional limits of all lower courts.

263. By reason of the foregoing, plaintiff by John Doe No. 4 demands judgment in the amount of $25,000,000.00 on the first count and cause of action for monetary damages inclusive of punitive damages.

WHEREFORE, plaintiff John Doe No. 4 demands judgment awarding monetary damages, including punitive damages, on the first count and cause of action (Negligence) in the Verified Complaint in the amount of $25,000,000.00 compensatory damages and punitive damages, amounts that exceed the monetary jurisdictional limits of all lower

courts which would otherwise have jurisdiction, together with the costs and disbursements of this action and the interest allowed by law.

Dated: New York, New York
October 7, 2019

Yours, etc.,

/S/ J. Lanni

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VERIFICATION

[redacted][9], otherwise known as plaintiff John Doe No. 4 (a/k/a "120653") for the purposes of this action, being duly sworn, deposes and states the following to be true under the penalties of perjury:

I am the plaintiff in the above captioned action.

I have read the annexed Summons and Verified Complaint and I know the contents of these documents.

The contents of these documents are true to my knowledge except for those matters that are stated to be alleged upon information and belief.

As to those matters alleged upon information and belief, they are believed by me to be true.

The matters alleged upon information and belief are based upon the facts, records, materials, investigation and information obtained by my attorneys and contained in my attorneys' files on this matter.

Dated: New York, New York
October 10, 2019

[redacted]

Sworn to before me this
10th day of October, 2019

[redacted]
Notary Public
[redacted]

[9] "John Doe No. 4 (a/k/a "120653") is an alias and pseudonym for the true identity of the plaintiff in this action; it is used to protect the privacy and identity of the plaintiff who is a sexual offense victim pursuant to N.Y. Civil Rights Law § 50-b and the true name and signature of the plaintiff has been redacted from this Verification under the statute for the same reasons. The original unredacted version of this verification will be produced to the court upon request.